NEGOTIATED RULEMAKING COMMITTEE ON THE SHARED RISK EXCEPTION

MINUTES[1]

October Meeting
October 8-10, 1997
Washington, D.C.

On October 8-10, the Negotiated Rulemaking Committee on the Shared Risk Exception held a negotiation session. (See **Attachment A** for a list of appointed Committee Members and their Alternates who attended the meeting.) The purpose of the meeting was to discuss options for resolving the "primary issues" as revised at the September meeting, to discuss new options developed for defining "substantial financial risk," to identify reasons why Members could not concur with particular proposed options, and to determine the next steps in the negotiations.

The meeting was noticed in the Federal Register and was open to the public. The meeting was held in the HHS Cohen Building in Washington, D.C.

FIRST DAY, OCTOBER 8, 1997

The facilitators reviewed the proposed meeting agenda, and explained that they had distributed copies of a revised options document (dated 10/7/97) that is essentially Appendix C to the September minutes, with the following added: 1) topic names for the issue groups previously identified by symbols; and 2) an option generated at the September meeting for resolving the issue of whether the items or services must be medical (page 6 of the 10/7/97 version).

Examples of "bad things"

In response to a request that the Committee first discuss factual scenarios regarding what the Committee does not want the exception to protect, the following hypothetical examples were identified:

Example 1: In an arrangement between an insurer and a supplier, the supplier provides a discount to the

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[1] These minutes were prepared by the facilitators for the convenience of the Committee Members and should not be construed to represent the official position of the Committee or of any Member on what transpired at the meeting.

insurer on patients enrolled in the insurer's capitated plan in order to get Medicare fee-for-service (FFS) patients from the insurer's employer business. A variation of this would be where a nursing home pays a respiratory therapy supplier a below-market capitation rate for some services but also gives the supplier FFS business (not covered by the capitation rate). In such situations, even if the FFS payment is under a fixed fee schedule, the arrangement could increase program costs by leading to increased volume of FFS claims.

Example 2: A managed care organization (MCO) contracts with a physician-hospital organization (PHO), which then subcontracts with hospitals and doctors, paying an above-average capitation rate to the doctors to get their FFS business on the side--in effect, paying them to keep them in the relationship, as well as to get their patients. This is especially a concern where the organization above is owned by people down the chain (although may be of less concern for a “top” tier organization with a contract with HCFA).

Example 3: The medical supervisor of a hospice gets paid by the hospice for his supervision services on a per patient per month (pp/pm) basis and also has a private practice from which he refers patients to the hospice. In effect, the medical supervisor is getting paid to refer patients to the hospice (since what he receives is contingent on the number of patients). Since the pp/pm mechanism arguably is a risk-sharing arrangement, however, it could conceivably fit within the shared risk exception. At a minimum, it would be difficult to prove beyond a reasonable doubt the intent to provide a kickback.

Example 4: A nursing home has an arrangement with a clinical laboratory providing for laboratory services for managed care patients at a low rate; in exchange, the laboratory provides free goods to the nursing home (for example, use of computers) and also gets the nursing home s FFS patients.

Example 5: An employer group health plan (EGHP) obtains the benefit of a lower rate on current employees because the EGHP is also referring retired employees with primary coverage by Medicare, for whom the EGHP is liable only as secondary payor. (This becomes a greater concern as the Medicare population in EGHPs rises.)

Discussion of these examples raised the following questions:

- Whether concerns about "swapping" a low capitation rate for FFS business could be addressed by requiring that the capitation rate be at fair market value or that anticipated utilization rates be prospectively set based on actuarially sound data;

- Whether the arrangements between any two parties would have to be fully set out in the written agreement; and

- Whether the concern with Example 2 is too sweeping, and could cover relationships happening by accident where there is no increase in program costs or utilization and therefore no antikickback concern.

The Committee then broke into caucuses.

After lunch, Committee Members reported on options being developed during caucus for defining "substantial financial risk" using either a "numerical" or a "non-numerical" approach.

Report on "numerical" option for defining "substantial financial risk"

Committee Members developing a "numerical" option for defining "substantial financial risk" reported that they were considering proposing a regulation including the following three elements (each of which would be an alternative way an arrangement could be protected under the shared risk exception):

- The first element/alternative would cover types of financial arrangements that by their nature would be considered as involving substantial financial risk--for example, capitation in a physician context, percent of premium, or a diagnosis-related group (DRG) payment.

- The second element/alternative would cover certain arrangements that meet a numerical standard, determined according to a methodology similar to the physician incentive plan (PIP) rule.

- The third element/alternative (on which there was no consensus in caucus, but clearly a possible

position) would recognize the diversity in the marketplace (such as rural v. urban) and would be a non-numerical standard linked to actuarial soundness and promoting efficient utilization.

With each element, there would be something akin to a safeguard, linked to soundness of the arrangement.

Report on "non-numerical" option for defining "substantial financial risk"

Committee Members working on a non-numerical approach in caucus reported that they were discussing a regulation defining "substantial financial risk" that would have three parts:

- An introduction that would discuss the objective of the regulation to provide a context for anyone who wants to apply the standard and fit within the exemption.

- A set of three "safe harbors" addressing risk-sharing arrangements based on marketplace experience:
  - A process safe harbor, requiring that the risk-sharing arrangement is founded on a written agreement including goals on coordination of care, appropriate utilization, and improvement of outcomes; the population is defined (based on size or composition); there is a process for monitoring outcomes/progress; there is an enforcement mechanism tied to financial incentives or termination of the contract; the risk could not be offset by a "swap" for FFS business; and the arrangement would have to pass a "laugh test" based on community standards (to address, for example, an excessive capitation amount).
  - A financial arrangement safe harbor to protect arrangements that are generally recognized as managed care (capitation, percentage of premium, substantial fee withholds, bonus or penalty arrangements, global fees, prospective per diem rates, and DRGs), describing these with appropriate limits so they are not disguised shams (for example, the arrangement could not be subject to a "swap", could not have a narrow risk corridor with reinsurance, and would have to be actuarially sound).

- An impact safe harbor that would evaluate on a prospective basis (using actuarial analysis or historical data) whether the arrangement improperly increases utilization or costs (where an increase in services at a lower level based on a medical judgment would not be improper--for example, an increase in home health services coupled with a decrease in unnecessary skilled nursing facility services).

- A method to analyze any risk-sharing arrangement that does not fall within a "safe harbor" that would pose a series of questions to see whether the arrangement would qualify for the exemption (for example, whether the risk-sharing arrangement is likely to increase the utilization of items or services that the provider is obligated to provide).

Committee Members involved in developing this option explained that an arrangement would be protected if it fell within one of the "safe harbors" in the second part of the regulation **or** if it qualified based on the case-by-case analysis set out in the third part of the regulation. They compared the case-by-case analysis to the "rule of reason" analysis used in the antitrust policy statement.

When asked why the need for a case-by-case analysis could not be met through the IG s advisory opinion process, they indicated that providers entering into these arrangements want more guidance and comfort at the outset, but without spending the time and money to go through the advisory opinion process. They said that thousands of new arrangements are developing each year, the vast majority of which will not go through the advisory process, and that setting up a regulatory framework of principles on which to rely in constructing these arrangements would facilitate the movement of the market toward managed care.

One Member clarified that going through the analysis would not automatically make an arrangement safe (because the parties to the arrangement could be wrong about it). Law enforcement representatives indicated a **concern** that this could be problematic in establishing criminal intent since standards of "reasonableness" in such an analysis appear to be the types of standards that would be in the "eye of the beholder". Such standards are not conducive to proof or disproof in a prosecution, they indicated. Moreover, one said, the administrative action of

excluding a provider from federal programs may not be a viable alternative to criminal prosecution in such circumstances (even if the burden of proof is less) since, if a provider merely made a "mistake," it would be hard to establish a need to protect the program by excluding the provider.

Concerns expressed about the proposed process safe harbor included that sham arrangements might qualify, that the arrangement would not necessarily place someone at substantial financial risk, and that back-end enforcement through termination of the arrangement might be too remote to effect utilization.

Concerns expressed about the proposed financial arrangements safe harbor included questions about how to evaluate whether a bonus or withhold meets the goal, and a question about whether the exclusion of narrow risk corridors should depend on the nature of the provider.

One Committee Member noted that it appeared that the financial arrangements safe harbor conceptually is close to the first element of the numeric approach. The difference, another Member noted, is that the non-numeric approach would describe the arrangement in narrative terms, rather than attaching numbers.

After discussing what the caucuses were considering, Committee Members called another caucus that lasted for the rest of the first meeting day.

SECOND DAY, OCTOBER 9

After the Committee reconvened, a caucus was again called. The facilitators pointed out the difference between a workgroup that is formed by the Committee under Groundrule 3.b. and open to any Member, and a caucus, which may be called by any Member at any time under Groundrule 6.f., and may be a caucus of interests that view themselves as allied around a particular issue or matter. The facilitators also noted that Groundrule 2.e. provides that a Committee Member or that Member s alternate must attend each meeting and that attendance will become increasingly important as options are refined.

Before Members went into caucus, it was mentioned that there were two issues related to defining substantial financial risk that needed to be addressed: the tier/organization issue, and the issue of whether the exception covers all, none, or only part of any items or

services for which the individual or entity may be rewarded.

More fully developed "numerical" option for defining "substantial financial risk"

Members working in caucus on a "numerical" option for defining "substantial financial risk" presented a report on their progress, outlining the "big picture" proposal they are continuing to refine. The outline of the proposal is in **Attachment B** and retains the three elements described the first meeting day, each of which would be an alternative way of qualifying for the exception.

In presenting the **first element/alternative** (see Attachment B at page 6), the proposers noted that--

- the list of arrangements in the first element/alternative should not be construed as exclusive at this point since it is just an attempt to get a loose consensus on concept;
- "case rate" would be defined as something similar to a DRG, but not based on diagnosis (for example, it might be a hospital rate based on treatment, where there is a fixed dollar amount paid regardless of length of stay);
- percent of premium would be an amount that is a certain percent of an amount paid to an upstream contractor (for example, 40% of a capitation rate paid to a Medicare contractor);
- the group was not yet sure whether to include the stop-loss qualifier and maybe it is unnecessary if the stop-loss market itself provides assurance that excessive stop-loss could not be obtained; and
- a protection under a DRG system for "outliers" would generally be considered a reasonable stop-loss protection.

In presenting the **second element/alternative** (the percent of risk formula set out in Attachment B at page 7), the proposers noted that--

- this element was discussed in the context of physicians/physician groups, but could apply to others as well;
- they had discussed using 10% as the percent of risk required to qualify, but had not reached consensus on this;
- the potential upside gain used in the numerator of

the percent of risk calculation would include only those incentives tied to utilization, not incentives tied to some other criterion (although there might be a provision requiring that the arrangement include quality incentives; and

- they considered using risk corridors, but need to explore that issue more.

The following explanation of **how to calculate the percent of risk** was given:

> If a physician is entitled to receive 100 units of payment, but 10 units are withheld until the end of the year, the base pay is 90 units. Even if there is an opportunity for a bonus at the end of the year, the base pay is still 90 units. If there is a possibility that the physician might have to pay money at the end of the year to cover a risk pool deficit, this potential obligation is not calculated into the base pay. In identifying the potential upside gain, all dollars based on utilization or costs would be estimated, using a reasonable analysis based on projected cost, utilization, and distribution. If it is expected that the 10-unit withhold would be returned plus a bonus of 5 units gained, the potential upside gain would be 15. The percent of risk would be calculated by dividing 15 (the potential upside gain) by 90 (the base payment amount), which equals about 16%.

The proposers explained that the **percent of risk formula differs from the PIP calculation** because:

- Under the PIP rule, risk is measured by theoretical gain or loss. If a physician is entitled to a bonus and the contract does not limit the bonus, so theoretically the physician could triple his/her income if there was no hospital utilization, HCFA would consider that the potential gain would be the triple income figure. The concern was that this would make it easy for providers to "game" the system by artificially inflating the amount of risk. In talking about upside gain, it is better to use a reasonable projection.

- The denominator in the PIP rule is total compensation, which is different from the base payment (essentially a "guaranteed amount"). The

base payment approach is simpler.

- The base payment amount does not factor in unquantifiable downside risk amounts, since those amounts are fairly subjective.

The **concern** was expressed that, if the base payment approach does not recognize potential downside loss, it would not recognize situations where that risk is substantial, for example, where a hospital might be required to fund a risk pool deficit at the end of the year. It was noted that some arrangements limit the liability for funding a risk pool deficit, but others do not. Some Members expressed the opinion that liability for funding a deficit in a risk pool is no more theoretical than a bonus.

Another **concern** was whether the calculation of upside gain is restricted to limits on utilization or could take into account bonuses for appropriate levels of utilization, such as a bonus tied to immunization levels. The proposers indicated they had not yet decided this.

The proposers noted with respect to **the third element/alternative** (see Attachment B at page 8) that--

- this part of their proposal is the least developed but the most closely linked to the non-numerical approach;
- they thought there may be circumstances not covered by the first two elements (for example, rural communities or rates such as prospective per diem rates) where a lower level of risk might still be considered substantial;
- the idea would focus on incentives that an actuary experienced in setting managed care rates would recognize as adequate to promote effective, appropriate utilization;
- there was no consensus on whether an opinion by someone other than an actuary would be acceptable; and
- there are remaining issues on what the person would certify to.

More fully-developed non-numerical option for defining "substantial financial risk" and discussion of "no swap"

After lunch, proposers of a non-numerical option for defining substantial financial risk, reviewed their proposal, which is outlined in **Attachment B.**

Essentially, the option contains the three parts described the previous day, except without the concept of actuarial soundness in the financial arrangements safe harbor. Since this concept is inherent in the definitions of what would be protected, the proposers indicated, they focused on the "no swap" protection. In addition, they noted, they feel there are extant definitions of these arrangements that can be relied on. They noted that they had not done further work on the impact safe harbor, had just started to work on the method of analysis for the third part of the regulation.

The **proposed provision to address the "no swap" concern** would state that payments under the written agreement must not be calculated with reference to compensation between the organization and the individual or entity that result in increased payments being claimed from a Federal health care program. This led to a lengthy discussion of whether the important criterion should be 1) whether a "swap" deal (you give me this for that) would increase costs to a Federal health care program; or 2) whether there was any express or implied agreement that one deal is contingent on another deal. Law enforcers indicated they would not be comfortable with any deal that used government patients as a bargaining tool and that they would judge a "swap" by intent. They said that all parts of a package must be commercially reasonable. A capitation rate could not be based on the profits on other deals. Whether an insurer could say that it would not do business with a provider on an individual product, but only if the provider signed up for the MC, FFS, and PPO products, might depend--this type of channeling could be used to extract a price.

Provider and health plan representatives indicated a concern that the law enforcement approach would prohibit arrangements that are common in the marketplace and do not lead to increased costs of the federal programs. An example discussed was that an insurer might offer to a group of doctors treating only AIDs patients a capitation rate that would be considered reasonable in the particular State, but too low for AIDs patients, and could be accepted by the doctors only because the insurer would also give them a large population of FFS patients through the insurer s PPO.

Sophisticated providers, one Member said, look at the mix of reimbursement and make decisions based on known volumes on reimbursement types and on the margins related to multiple deals. Moreover, some Members said, HCFA and

some States require that providers serve commercial enrollees as well as program patients, and a State might make coverage of State employees contingent on acceptance of Medicaid recipients as well. Not all of these arrangements would have the "remuneration" necessary to constitute a kickback, the law enforcers said, but merely because an arrangement is common, this does not mean it should be protected.

The following provision from the IG regulations was offered by a provider Member as possibly addressing the "no swap" concern:

> . . . the contract health provider must not claim payment in any form from the Department or the State agency for items or services furnished in accordance with the agreement except as approved by HCFA or the State health care program, or otherwise shift the burden of such an agreement to the extent that increased payments are claimed from Medicare or a State health care program.

42 C.F.R. 1001.952(m)(1)(i). It was noted that this provision was written more broadly in the proposed rule and narrowed in the final rule.

There was no consensus on whether adopting this provision would address the "no swap" concern.

Discussion of differences between the two options

The Committee then discussed differences between the two options for defining substantial financial risk, with some Members questioning why the concept of actuarial soundness had been dropped in the non-numerical option. The response was that the concept would be incorporated into the definition in a narrative way. One proponent of the numerical option noted that the types of payments covered in the first element/alternative of that option would work only if they were built on an actuarial basis, but that an actuarial opinion would not be required.

One Member explained why "global fees" were not included in the numerical option: if a global fee is really a "bundled fee," it could be a disguised kickback (although a flat rate for OB/GYN services could be okay).

In response to a question about the non-numerical option, one Member described a "substantial fee withhold" as a fee withhold that is large enough to influence the practice pattern of the provider. He explained that they wanted to recognize that different providers have different thresholds. It was noted that criteria would be needed for determining determine whether a fee withhold is "substantial" (large enough) and that there have been some advisory opinions that look at this question.

A bonus was described as a situation where there is no withhold of a portion of provider fees, but where a pool is created that providers can access when they meet a predetermined utilization budget or quality measure. The bonus might be an aggregate amount, tied to performance of the whole network, not just individual performance. Questions were raised about whether a bonus tied to quality measures and not to utilization would meet the goal of the exception, or could be a subterfuge (a way to cover up additional money that the provider would be assured of receiving). One Member noted that utilization can affect bonuses in two ways in most arrangements with which she is familiar: by increasing the size of the pool to be distributed and when distributing the pool.

Since a quorum was no longer present, the Committee adjourned at about 4:00, after requesting that the facilitators type up an outline of the options discussed, so that the two options could be more easily compared.

THIRD DAY, OCTOBER 10

In the morning, the facilitators distributed a typed outline of the two options for defining substantial financial risk presented over the previous two days (**Attachment B**), asking Members to point out any inaccuracies. The Committee then discussed the day, deciding to adjourn at 1:00, but to work through lunch. The Committee also discussed whether to reconsider the request by MIM, Inc. to make an oral presentation to the Committee to supplement its written statement dated September 22, 1997, which had been distributed to the Committee. In light of Committee concerns regarding the remaining time to achieve consensus, the Committee again concurred that MIM, Inc. would have the same opportunity to sign up for an oral statement accorded to the rest of the public. (No one signed up to make an oral statement at this meeting.)

After a preliminary discussion on the next steps toward

defining substantial financial risk, the Committee decided to discuss related issues first.

Discussion of tier/organization issues

The Committee then discussed the tier/organizations issues starting on page 1 of the 10/7/97 revised options document. The Committee reviewed the definition of "health plan" at 42 CFR 1001.952(l)(2), which is one of the options for defining "organization" for purposes of the second prong of the exception. The IG representative clarified the IG s current interpretation of the definition of "health plan," indicating that--

- an entity that signs a Medicare+Choice contract with HCFA would be covered except for an unrestricted FFS plan or a medical savings account plan;
- under subsection (i) the entity must have an agreement with HCFA; and
- a provider agreement with HCFA would not qualify.

Hospital representatives questioned why an arrangement between a PHO and a Medicare section 1876 contractor would not be covered since the definition of "health plan" refers to an agreement "approved by" HCFA, an arrangement with a PHO would be included in the risk contract with HCFA, and HCFA would be looking at the "big picture." One questioned whether it makes sense to use the "health plan" definition since this definition is already included in the regulatory safe harbors and there would be no need for the statutory exception if Congress did not intend to cover arrangements not already protected. Another noted that there is no indication in the statutory exception that an "organization" is limited or must be the top tier contractor.

The IG representative expressed concern with any definition that would let an organization be free-floating (not part of an overall managed care plan) and, for example, would protect an arrangement between a nursing home and a therapy provider. The rationale for limiting the definition of organization, he said, is that it is related to "eligible organizations" under section 1876.

There are two ways to examine the issue, according to one Member: 1) analyze the language of the statute (what did Congress mean?); and 2) look at the environment (what makes sense?). The reality, he said, is that the vast

majority of the risk sharing arrangements as to provider contracts are not at the first tier, but further downstream. This led to a discussion of whether bottom tiers could be protected if there is risk at the top and risk sharing along the way. The IG representative indicated that he was not prepared to answer "yes", but that the IG and DOJ were still discussing this question. If there is no risk above, the primary concern is the "swap" question. Whether "swap" is a concern for an EGHP, might depend on whether the MCO or the provider bills FFS, one Member said. Another said that the concern about an EGHP is a PPO plan where the employer gets a cheaper rate on employees because he is delivering Medicare retirees (a "pull through" issue).

One Member questioned whether arrangements downstream from a State s contract with a County would be protected, and was told that this would depend on how the Committee resolves the tier question.

Some Members expressed concerns about requiring risk above, including that the statute does not require it and that hospitals and doctors could not then qualify for the exception if they were in a region without a certified health plan. One Member said the starting point for defining an "organization" should be what is "non-eligible." He read the section 1876 definition of "eligible organization" and proposed basically the following **option for defining "organization"**:

> a public or private entity organized under the laws of any State which provides health care services [but does not have to provide all services that an "eligible organization" must provide].

The Committee then discussed whether they could identify any risk arrangements that would not be "downstream" from another risk arrangement that they would want to protect. The following were identified as possibly being such arrangements :

- an employer plan in which there is risk-sharing for most employees, even though downstream payments are on a FFS basis where Medicare is primary--the risk sharing is meaningful because most dollars are paid by the employer; and
- a HCFA contractor paid on an FFS basis paying a capitation payment to a group member.

The Committee then clarified that there are now **four options for defining "organization":** 1) only first tier; 2) any contracting tier; 3) any contracting tier where risk flows through from the top; and 4) any contracting tier where there is risk at the top, even if it does not flow through.

Consensus was not reached. Committee Members agreed to try to identify **whether there are any additional arrangements that should be protected that would not be protected if option 3 were adopted.**

Discussion of options for issues on what items and services are covered

The facilitators reviewed the following categories of items or services, as clarified at the September meeting (page 5 of the 10/7/97 revised options):

Category 1. Those the individual or entity provides directly by employees.
Category 2. Those the individual or entity is financially responsible for (including subcontracts if the individual or entity pays the subcontractor, the MCO pays the subcontractor on behalf of the individual or entity, or the subcontractor is paid by reinsurance the individual or entity has obtained).
Category 3. Those for which the individual or entity does not receive payment but for which the individual or entity may be rewarded:

- **Subcategory A.** Those where there is a close relationship between the compensation the individual or entity receives and particular items or services.
- **Subcategory B.** Those where compensation is tied collectively to efficiencies.

At the September meeting, the Committee reached consensus that the items and services in **Categories 1 and 2**, as described above, are covered by the phrase "obligated to provide". Options for resolving the remaining issue are to include all of Category 3, exclude all of Category 3, or to include Subcategory A, but exclude Subcategory B. (The distinction between Subcategory A and Subcategory B was ultimately explained as follows, in the context of an HMO physician incentive plan: There would be a close relationship between the compensation and particular items or services if the panel of doctors whose risk is collectively considered is small--for example, a group of 10 doctors. As the number of physicians who share in the risk increases, dilution occurs. Subcategory B would start at the undefined point where there is a diminished

effect on utilization.)

A “numerical” caucus member indicated that that group recommended that all of Category 3 be included and that this was reflected in what would be included in the “potential upside gain” (the numerator of the percent of risk calculation). It was clarified that including rewards for Category 3 item/services in the numerator would not require including anything different in the denominator, since the denominator is defined as the base payment amount received during the year (the guaranteed amount, not counting any risk-based distribution). It was further explained that this denominator was chosen since, according to an actuary consulted by the caucus, that is the amount that is the frame of reference for the providers, who think about what money might they get in addition to that.

Some Members noted that the statutory language “obligated to provide” in the second prong of the exception could be considered to encompass referrals made by a physician because, a physician is required to make referrals: for example, if a patient is having a heart attack, the physician must send the patient to a hospital.

The IG representative noted that the language of the statute clearly covers Categories 1 and 2, but does not clearly cover Category 3 although they understand that not covering Category 3 is problematic regarding how physicians are compensated. He asked Committee Members **whether this is just a physician problem**.

A hospital representative said that hospitals pay remuneration to physicians to affect referral patterns and would want these arrangements protected. A nursing home representative said that she would need to explore whether Category 3 would relate to arrangements downstream from an SNF that accepts a per diem or partial cap. A pharmacy representative indicated that pharmacies may get a bonus for providing certain extra services such as making sure a patient takes a medication properly or gets a prescription refilled, where the bonus is for overall patient wellness at the end of the year and could be a collective bonus. Another Member noted that a hospital DRG rate for cardiac patients would not include cardiac rehabilitation provided by physical therapists, but a hospital arranges for these services.

The facilitator asked whether there was still an issue regarding whether the services needed to be “medically

necessary". The Committee reached **CONSENSUS** to drop this as an issue.

Next step in the negotiations

The Committee Members then discussed various options for how to move the negotiation process forward, in light of the fact that there are only two scheduled meetings left, with no guarantee that more will be scheduled. They noted that they needed to consult with their constituents regarding the options presented and to obtain further information about what they would want to protect that might not be protected by certain options.

They agreed that **those who wish to share with others the input they receive from their constituents regarding the options for resolving how to define "substantial financial risk" will do so either by participating in a caucus by telephone on November 7 from 10:00 a.m. to noon or by transmitting the information through another Member who participates. The facilitators will send Committee Members instructions on how to connect to the conference call. Any Member or caucus of Members wishing to use the information to develop a new option (such as a hybrid) or to refine one of the two existing options should submit the option to the facilitators by a date to be set in the conference call. The new options will then be sent to Committee Members before the November meeting.**

Next Meeting

The next meeting will start November 19 at 9:00 a.m. and go until 5:00 p.m. on November 21. The meeting will be held in rooms 383 and 385 of the Hall of the States at 444 North Capitol Street, Washington, D.C. (near Union Station). The Committee will continue discussing options for resolving the remaining primary issues. In addition, there may be a presentation on reinsurance (to be discussed in the November 7 call), and Committee Members may try to have actuaries present to assist the Committee's deliberations.

ATTACHMENT A - LIST OF PARTICIPANTS

Committee Members present for part or all of the meeting:

Cheryl Matheis, American Association of Retired Persons
Candace Schaller, American Association of Health Plans
Ken Burgess, American Health Care Association
Mary R. Grealy, American Hospital Association
Edward B. Hirshfeld, American Medical Association
Brent Miller, American Medical Group Association
Susan E. Nestor, BlueCross BlueShield Association
Charles P. Sabatino, Consumer Coalition for Quality Health Care
Missy Shaffer, Coordinated Care Coalition
Laura Steeves Gogal, Federation of American Health Systems
Eddie Allen, Health Industry Manufacturers Association
Kylanne Green, Health Insurance Association of America
Stephen M. Spahr, National Association of Medicaid Fraud Control Units
Karen A. Morrissette, Department of Justice
Don Brain, IIAA/NAHU/NALU

Alternates substituting for Committee Members:

Marjorie Powell, PhRMA
Brent Philips, TIPAAA
Jennifer Goodman, NASMD

Alternates attending and/or substituting for Committee Member for part of the meeting:

Mark Joffe, AAHP; Elise Smith, AHCA; Kathy Nino, AMA; Mary L. Kuffner, AMGA; Julie Simon Miller, BCBSA; Jonathon M. Topodas, CCC; Bob Wallace, DOJ; Thomas Bruderle, NAHU; Douglas Guerdat, BCBSA; Kathleen Fyffe, HIAA.